Suicide Risk Assessment in OEF/OIF/OND Veterans

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Agenda

- General Risk Assessment
  - Suicide Risk Assessment Language
  - Overview of Suicide Risk Assessment
  - Suicide-Specific Assessment Tools
  - Suicide-Focused Psychiatric Interview
  - Risk Factors and Warning Signs
- Additional Considerations for OEF/OIF/OND Veterans
  - PTSD
  - Substance abuse
  - TBI

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OIF and Suicide/Homicide

- **425** patients (Feb – Dec, 2004) – Evaluated by the MH Team at Forward Operational Base Speicher
  - 23% Reserves, 76% Active Duty Army, 1% Active Duty AF
    - 19% Combat Units, 81% Support Units
      - 127 had thought of ending life in the past week
        - 81 had a specific suicide plan
      - 26 had acted in a suicidal manner (e.g. placed weapon to their head)
        - 67 had the desire to kill somebody else (not the enemy)
          - 36 had formed a plan to harm someone else
            - 11 had acted on the plan
- **75** of the cases were deemed severe enough to require immediate mental health intervention
  - Of the 75 soldiers, 70 were treated in theater and returned to duty
    - **5 were evacuated**

Hill et al 2006

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Is a common language necessary to facilitate suicide risk assessment?

Do we have a common language?

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The Language of Self-Directed Violence

Identification of the Problem

- Suicidal ideation
- Death wish
- Suicidal threat
- Cry for help
- Self-mutilation
- Parasuicidal gesture
- Suicidal gesture
- Risk-taking behavior
- Self-harm
- Self-injury
- Suicide attempt
- Aborted suicide attempt
- Accidental death
- Unintentional suicide
- Successful attempt
- Completed suicide
- Life-threatening behavior
- Suicide-related behavior
- Suicide

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Self-Directed Violence Classification System (SDVCS)

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Type	Sub-Type	Definition	Modifiers	Terms
Thoughts	Non-Suicidal Self-Directed Violence Ideation	Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence Ideation in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).	N/A	•Non-Suicidal Self-Directed Violence Ideation
	Suicidal Ideation	Self-reported thoughts of engaging in suicide-related behavior. For example, intrusive thoughts of suicide without the wish to die would be classified as Suicidal Ideation, Without Intent.	•Suicidal Intent -Without -Undetermined -With	•Suicidal Ideation, Without Suicidal Intent •Suicidal Ideation, With Undetermined Suicidal Intent •Suicidal Ideation, With Suicidal Intent
Behaviors	Preparatory	Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away). For example, hoarding medication for the purpose of overdosing would be classified as Suicidal Self-Directed Violence, Preparatory.	• Suicidal Intent -Without -Undetermined -With	•Non-Suicidal Self-Directed Violence, Preparatory •Undetermined Self-Directed Violence, Preparatory •Suicidal Self-Directed Violence, Preparatory
	Non-Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).	• Injury -Without -With -Fatal • Interrupted by Self or Other	•Non-Suicidal Self-Directed Violence, Without Injury •Non-Suicidal Self-Directed Violence, Without Injury, Interrupted by Self or Other •Non-Suicidal Self-Directed Violence, With Injury •Non-Suicidal Self-Directed Violence, With Injury, Interrupted by Self or Other •Non-Suicidal Self-Directed Violence, Fatal
	Undetermined Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based upon the available evidence. For example, the person is unable to admit positively to the intent to die (e.g., unconsciousness, incapacitation, intoxication, acute psychosis, disorientation, or death); **OR** the person is reluctant to admit positively to the intent to die for other or unknown reasons.	• Injury -Without -With -Fatal • Interrupted by Self or Other	•Undetermined Self-Directed Violence, Without Injury •Undetermined Self-Directed Violence, Without Injury, Interrupted by Self or Other •Undetermined Self-Directed Violence, With Injury •Undetermined Self-Directed Violence, With Injury, Interrupted by Self or Other •Undetermined Self-Directed Violence, Fatal
	Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent. For example, a person with a wish to die cutting her wrist with a knife would be classified as Suicide Attempt, With Injury.	• Injury -Without -With -Fatal • Interrupted by Self or Other	•Suicide Attempt, Without Injury •Suicide Attempt, Without Injury, Interrupted by Self or Other •Suicide Attempt, With Injury •Suicide Attempt, With Injury, Interrupted by Self or Other •Suicide

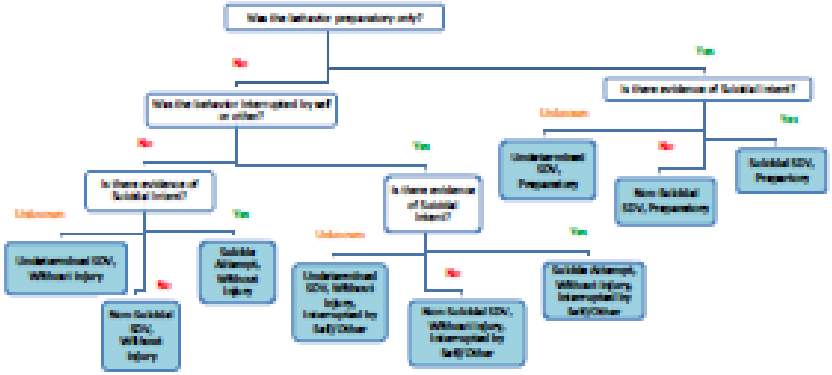
Self-Directed Violence (SDV) Classification System
Clinical Tool

BEGIN WITH THESE 3 QUESTIONS:

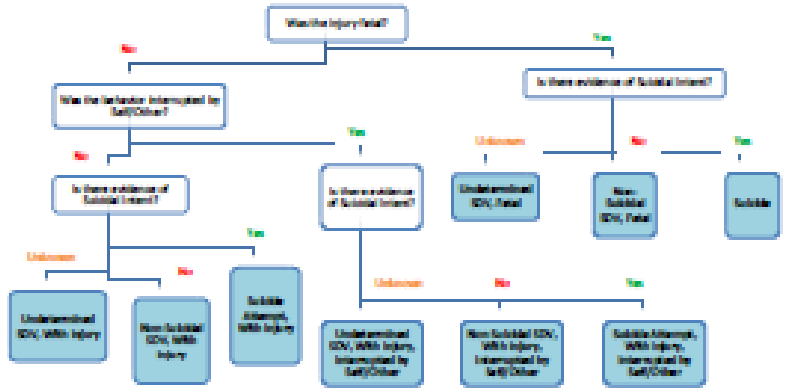
1. Is there any indication that the person engaged in self-directed violent behavior, either preparatory or potentially harmful? (Refer to Key Terms on reverse side)
   If NO, proceed to Question 2; If YES, proceed to Question 3
2. Is there any indication that the person had self-directed violence related thoughts?
   If NO to Questions 1 and 2, there is insufficient evidence to suggest self-directed violence → NO SDV TERM
   If YES, proceed to Decision Tree A
3. Did the behavior involve any injury?
   If NO, proceed to Decision Tree B
   If YES, proceed to Decision Tree C

DECISION TREE A: THOUGHTS

DECISION TREE B: BEHAVIORS, WITHOUT INJURY



DECISION TREE C: BEHAVIORS, WITH INJURY



Self-Directed Violence (SDV) Classification System
Clinical Tool

Key Terms (Centers for Disease Control and Prevention)

Self-Directed Violence:	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.
Suicidal Intent:	There is past or present evidence (explicit and/or implicit) that the individual intended to kill him/herself and wished to die, and that he/she understood the probable consequences of his/her actions or potential actions.
Preparatory Behavior:	Acts or preparation towards imminently making a suicide attempt, but before potential for harm has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away).
Physical Injury (paraphrased):	A bodily lesion resulting from acute overexposure to energy (this can be mechanical, thermal, electrical, chemical, or radiant) interacting with the body in amounts or rates that exceed the threshold of physiological tolerance (e.g., bodily harm due to suffocation, poisoning or overdoses, lacerations, gunshot wounds, etc.). Refer to the Classification System for the full CDC definition.
Interrupted By Self or Other	A person takes steps to injure self but is stopped by self/another person prior to fatal injury. The interruption may occur at any point.
Suicide Attempt:	A non-fatal self-inflicted potentially injurious behavior with any intent to die as a result of the behavior
Suicide:	Death caused by self-inflicted injurious behavior with any intent to die as a result of the behavior

Reminder: Behaviors Trump Thoughts

SDVCS- Additional Information

http://www.mirecc.va.gov/visn19/education/nomenclature.asp

- SDVCS Training (audio presentation)
- On-Line Decision Tree
- SDVCS for your Smartphone
- Free SDVCS Toolkit and Classification System Clipboards

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Now that we are using a common language…

How should we be assessing risk?

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We assess risk to…

- Take good care of our patients and to guide our interventions
- The purpose of systematic suicide risk assessment is to identify modifiable and treatable risk factors that inform the patient's overall treatment and management requirements (Simon 2001)
- Fortunately, the best way to care for our potential suicidal patients and ourselves are one in the same (Simon 2006)

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Suicide Risk Assessment

- Refers to the establishment of a clinical judgment of risk in the near future
- Based on the weighing of a very large amount of available clinical detail

Jacobs 2003

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Suicide Risk Assessment

- No standard of care for the prediction of suicide
- Suicide is a rare event
- Efforts at prediction yield lots of false-positives as well as some false-negatives
- Structured scales may augment, but do not replace systematic risk assessment

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Suicide Risk Assessment

- Standard of care does require suicide risk assessment whenever indicated
- Best assessments will attend to both risk and protective factors
- Risk assessment is not an event, it is a process
- Inductive process to generate specific patient data to guide clinical judgment, treatment, and management
- Research identifying risk and protective factors enables evidence-based treatment and safety management decision making

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Suicide Assessment Indications

- Emergency department or crisis evaluation
- Intake evaluation
- ***Prior to change in observation status or treatment setting***
- Abrupt change in clinical presentation
- Lack of improvement or gradual worsening with treatment
- Anticipation/experience of loss or stressor
- Onset of physical illness

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Using Suicide-Specific Assessment Tools to Further Suicide Assessment

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Elements of Useful Assessment Tools

- Clear operational definitions of construct assessed
- Focused on specific domains
- Developed through systematic, multistage process
  - empirical support for item content, clear administration and scoring instructions, reliability, and validity
- Range of normative data available

Gutierrez and Osman, 2008

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Self-Report Measures

- Advantages
  - Fast and easy to administer
  - Patients often more comfortable disclosing sensitive information
  - Quantitative measures of risk/protective factors

- Disadvantages
  - Report bias
  - Face validity

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Suicide Specific Self-Report Measures

- Self-Harm Behavior Questionnaire (SHBQ; Gutierrez et al., 2001)
- Reasons for Living Inventory (RFL; Linehan et al., 1983)
- Suicide Cognitions Scale-Revised (SCS-R; Rudd, 2004)
- Beck Scale for Suicidal Ideation (BSS; Beck, 1991)

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Self-Harm Behavior Questionnaire (SHBQ)

- Semi-structured interview
- Consists of both free response and forced choice options
- Evaluates both non-suicidal self-injury and suicide-related behaviors
- Assesses details about behaviors sufficient to gauge medical severity/lethality of suicidal behavior
- Scoring system weights responses based on seriousness such that higher subscale and total scores indicate greater suicide risk status

SHBQ Interpretation

- Suicidal ideation
- Suicide threats (communication)
- Non-suicidal self-injury (NSSI)
- Suicide attempts
- Method, frequency, recency, medical treatment (attempts, NSSI),associated stressors, intent

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Sample SHBQ Question

Times you hurt yourself badly on purpose or tried to kill yourself.

2. Have you ever attempted suicide? **YES** **NO**

If no, go on to question # 4.

If yes, how? _____

(**Note:** if you took pills, what kind? _____; how many? _____ ; over how long a period of time did you take them? _____)

a. How many times have you attempted suicide? _____

b. When was the most recent attempt? *(write your age)* _____

c. Did you tell anyone about the attempt? **YES** **NO**

Who? _____

d. Did you require medical attention after the attempt? **YES** **NO**

If yes, were you hospitalized over night or longer? **YES** **NO** How long were you hospitalized? _____

e. Did you talk to a counselor or some other person like that after your attempt? **YES** **NO** Who? _____

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Reasons for Living Inventory (RFL)

- Assesses for the importance of one's reasons NOT to make a suicide attempt
- 48 items
- Subscales
  - Suicide and Coping Beliefs
  - Fear of Social Disapproval
  - Responsibility to Family
  - Child-related Concerns
  - Fear of Suicide
  - Moral Objections

Linehan et al.

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RFL Directions

In each space put a number to indicate the importance to you of each for not killing yourself.

1 = Not at all important

2 = Quite unimportant

3 = Somewhat unimportant

4 = Somewhat important

5 = Quite important

6 = Extremely important

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Sample RFL Items

____ 1. I have a responsibility and commitment to my family.

____ 2. I believe I can learn to adjust or cope with my problems.

____ 3. I believe I have control over my life and destiny.

____ 4. I have a desire to live.

____ 5. I believe only God has the right to end a life.

____ 6. I am afraid of death.

____ 7. My family might believe I did not love them.

____ 8. I do not believe that things get miserable or hopeless enough that I would rather be dead.

____ 9. My family depends upon me and needs me.

____ 10. I do not want to die.

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Suicide Cognitions Scale-Revised

- Assesses the cognitive dimension of suicide-specific hopelessness
- 20 items rated on a 1-5 Likert scale
  - 1 = Strongly Disagree; 5 = Strongly Agree
- Four subscales
  - Unlovability
  - Helplessness
  - Poor Distress Tolerance
  - Perceived Burdensomeness

Rudd et al.

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Sample SCS-R Items

1) The world would be better off without me.
2) Suicide is the only way to solve my problems.
3) I can't stand this pain anymore.
4) I am an unnecessary burden to my family.
5) I've never been successful at anything.
6) I can't tolerate being this upset any longer.
7) I can never be forgiven for the mistakes I have made.
8) No one can help solve my problems.
9) It is unbearable when I get this upset.
10) I am completely unworthy of love.

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Beck Scale for Suicidal Ideation (BSS)

- Evaluates suicidal thinking
- Self-report, multiple choice measure
- Administration time: 5-10 minutes
- Self-administered or verbally administered by a trained administrator
- Training consists of reviewing the manual

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BSS Item Description

- 5 Screening Items
  - Reduce the length and intrusiveness of the questionnaire for clients who are not suicidal

- 21 Test Items

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"Although self-report measures are often used as screening tools, an adequate evaluation of suicidality should include both interviewer-administered and self-report measures."

http://www.suicidology.org/c/document_library/get_file?folderId=235&name=DLFE-113.pdf

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Important Domains of a Suicide-Focused Psychiatric Interview

- Psychiatric Illness
- History
- Psychosocial situation
- Individual strengths and vulnerabilities
- Current presentation of suicidality
  - Specifically inquire about suicidal thoughts, plans and behaviors

APA Practice Guidelines (2003)

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Specific Inquiry of Thoughts, Plans, and Behaviors

- Elicit any suicidal ideation
  - Focus on nature, frequency, extent, timing
  - Assess feelings about living
- Presence or Absence of Plan
  - What are plans, what steps have been taken
  - Investigate patient's belief regarding lethality
  - Ask what circumstances might lead them to enact plan
  - Ask about GUNS and address the issue

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Specific Inquiry of Thoughts, Plans, and Behaviors

- Assess patient's degree of suicidality, including intent and lethality of the plan
  - Consider motivations, seriousness and extent of desire to die, associated behaviors and plans, lethality of method, feasibility
  - Realize that suicide assessment scales have low predictive values
- ***Strive to know your patient and their specific or idiosyncratic warning signs***

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Identify Suicide Risk Factors

- Specific factors that may generally increase risk for suicide or other self-directed violent behaviors
- A major focus of research for past 30 years
- Categories of risk factors
  - Demographic
  - Psychiatric
  - Psychosocial stressors
  - Past history

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Warning Signs

- Warning signs – person-specific emotions, thoughts, or behaviors precipitating suicidal behavior
- Proximal to the suicidal behavior and imply imminent risk
- The presence of suicide warning signs, especially when combined with suicide risk factors generates the need to conduct further suicide risk assessment

Rudd et al. 2006

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Risk Factors vs. Warning Signs

Risk Factors

- Suicidal ideas/behaviors
- Psychiatric diagnoses
- Physical illness
- Childhood trauma
- Genetic/family effects
- Psychological features (i.e. hopelessness)
- Cognitive features
- Demographic features
- Access to means
- Substance intoxication
- Poor therapeutic relationship

Warning Signs

•Threatening to hurt or kill self or talking of wanting to hurt or kill him/herself

• Seeking access to lethal means

•Talking or writing about death, dying or suicide

•Increased substance (alcohol or drug) use

•No reason for living; no sense of purpose in life

•Feeling trapped - like there's no way out

•Anxiety, agitation, unable to sleep

• Hopelessness

•Withdrawal, isolation

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Risk Factors vs. Warning Signs

Characteristic Feature	Risk Factor	Warning Sign
Relationship to Suicide	Distal	Proximal
Empirical Support	Evidence-base	Clinically derived
Timeframe	Enduring	Imminent
Nature of Occurrence	Relatively stable	Transient
Implications for Clinical Practice	At times limited	Demands intervention

Rudd et al. 2006

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Determine if factors are modifiable

Non-modifiable Risk Factors

- Family History
- Past history
- Demographics

Modifiable Risk Factors

- Treat psychiatric symptoms
- Increase social support
- Remove access to lethal means

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Acute v. Chronic Risk

- These are very different, and each carry there own specific treatment/safety

  A 29 y/o female with hx of 18 suicide attempts and chronic suicidal ideation, numerous psychiatric admissions, family hx of suicide, gun ownership, TBI, intermittent homelessness, alcohol dependence, and BPD presents to ER with c/o SOB; asked to conduct psychiatric evaluation given her well-known history. What is her risk?

- Formulation and plan for such individuals necessitates separate consideration of chronic and acute risk

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Acute v. Chronic Risk

- Acute and chronic risk are dissociable
- Document estimation for each

  "Although patient carries many static risk factors placing her at high chronic risk for engaging in suicidal behaviors, her present mood, stable housing, sustained sobriety, and SI below baseline suggest little acute/imminent risk for suicidal behavior."

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Develop a Treatment Plan

- For the suicidal patient, particular attention should be paid to modifiable risk and protective factors
- Static risk factors help stratify level of risk, but are typically of little use in treatment; can't change age, gender, or history
- Modifiable risk factors are typically many: medical illness (pain), psychiatric symptoms (psychosis), active substance abuse, cognitive styles, access to means, etc

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Don’t Neglect Modifiable Protective Factors

- These are often key to addressing long-term or chronic risk
- Sense of responsibility to family
- Reality testing ability
- Positive coping skills
- Positive problem-solving skills
- Enhanced social support
- Positive therapeutic relationships

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Additional Considerations for Risk Assessment in OEF/OIF/OND Veterans

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PTSD and Suicide Risk

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PTSD and OEF/OIF

- Exposure to combat greater among those deployed to Iraq
- The percentage of study subjects who met screening criteria for major depression, generalized anxiety disorder, or PTSD
  - Iraq 15.6%-17.1%
  - Afghanistan 11.2%

Hoge et al 2004

Those with PTSD at Increased Risk for Suicidal Behavior

14.9 times more likely to attempt suicide than those without PTSD

(community sample)

(Davidson et al., 1991)

Over 4 times more likely to endorse suicidal ideation those without PTSD

(OEF/OIF screened sample)

(Jakupcak et al. 2009)

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Why?

- Veteran Population
  - Survivor guilt (Hendin and Haas, 1991)
  - Being an agent of killing (Fontana et al., 1992)
  - Intensity of sustaining a combat injury (Bullman and Kang, 1996)

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Potential Consequences of PTSD

Social and Interpersonal Problems:

- Relationship issues
- Low self-esteem
- Alcohol and substance abuse
- Employment problems
- Homelessness
- Trouble with the law
- Isolation

Self-harm used as a means of regulating overwhelming internal experiences

- Unwanted emotions
- Flashbacks
- Unpleasant thoughts

©Michael Kamber: Latifiyah, Iraq. May 19, 2007

Post-Traumatic Symptoms and Suicidality

- Avoidance/Numbing
- Hyperarousal
- Re-experiencing*

* Re-experiencing Symptom Cluster Associated with Suicidal Ideation

Nye et al., 2007

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Substance Abuse and Suicide Risk

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Substance Abuse and Suicide in Veteran Population

Characteristics	Male		Female	
	Hazard Ratio	95% Confidence Interval	Hazard Ratio	95% Confidence Interval
Any Psychiatric Diagnosis	2.50	(2.38, 2.64)	5.18	(4.08, 6.58)
Any Substance Abuse or Dependence	2.27	(2.11, 2.45)	6.62	(4.72, 9.29)
Alcohol Abuse or Dependence	2.28	(2.12, 2.45)	6.04	(4.14, 8.82)
Other Drug Abuse or Dependence	2.09	(1.90, 2.31)	5.33	(3.58, 7.94)
Bipolar Disorder	2.98	(2.73, 3.25)	6.33	(4.69, 8.54)
Depression	2.61	(2.47, 2.75)	5.20	(4.01, 6.75)
Other Anxiety	2.10	(1.94, 2.28)	3.48	(2.52, 4.81)
PTSD	1.84	(1.70, 1.98)	3.50	(2.51, 4.86)
Schizophrenia	2.10	(1.93, 2.28)	6.08	(4.35, 8.48)

Ilgen et al. (2010)

Alcohol Problems Post-Deployment

- 11.8% for Active Duty
- 15.0% for Reserve/Guard

Milliken, Auchterloine, & Hoge 2007

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Intoxication & Acute Risk

- Psychopharmacological effects on the brain
  - Impair problem solving
  - Impulsivity
  - Disinhibition

- Intoxication from alcohol and other substances may increase the likelihood of an individual acting on suicidal thoughts

Steele & Joseph, 1990

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TBI and Suicide Risk

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Risk Factors for those with a History of TBI

Individuals with a history of TBI are at increased risk of dying by suicide

Members of the military are sustaining TBIs

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Role of Pre-injury vs. Post-Injury Risk Factors

Post-injury psychosocial factors, in particular the presence of **post injury emotional/psychiatric disturbance** (E/PD) had far greater significance than pre-injury vulnerabilities or injury variables, in predicting elevated levels of suicidality post injury.

Higher levels of hopelessness were the strongest predictor of suicidal ideation, and high levels of SI, in association E/PD was the strongest predictor of post-injury attempts

Simpson and Tate 2002

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TBI and Psychiatric Co-morbidity

Respondents with a co-morbid history of psychiatric/emotional disturbance **and** substance abuse were 21 times more likely to have made a post-TBI suicide attempt.

Simpson and Tate 2005

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TBI and Suicide: Symptoms, Functioning and Outcomes

Rehabilitation Psychology
2009, Vol. 54, No. 4, 390–397

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Suicidality and Veterans With a History of Traumatic Brain Injury: Precipitating Events, Protective Factors, and Prevention Strategies

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Objectives: To increase understanding regarding precipitating and preventative factors of suicidal behavior and to highlight past experiences and recommendations regarding services aimed at suicide prevention among Veterans with a history of traumatic brain injury (TBI). ***Study Design:*** Qualitative. ***Participants:*** Sample of 13 Veterans with a history of TBI, and a history of clinically significant suicidal ideation or behavior. ***Method:*** In-person interviews were conducted and data were analyzed using a hermeneutic approach. ***Results:*** Shared precipitants noted included loss-of-self post-TBI, cognitive sequelae, and psychiatric and emotional disturbances. Common protective factors noted included social supports, a sense of purpose regarding the future, religion and spirituality, and mental health care. Means of improving care were also identified (e.g., increasing the availability of services and mental health professionals' knowledge regarding TBI, providing more structured treatment). ***Conclusions:*** Findings highlight potential areas of importance in the assessment and treatment of suicidal Veterans with a history of TBI. Recommendations regarding means of improving care are also presented.

Keywords: suicide, traumatic brain injury, Veterans, qualitative

Populations identified as being at increased risk for suicidal behavior include Veterans (Kaplan, Huguet, McFarland, & Newsom, 2007) and individuals with a history of traumatic brain injury (TBI) (Simpson & Tate, 2007). Kaplan et al. (2007) found U.S. male military Veterans, age 18 and older, to be twice as likely to die by suicide as non-Veteran males. Depending on the type of injury sustained, suicide rates among individuals with a history of TBI are estimated to be between 2.7 and 4.0 times higher as compared to the general population (Teasdale & Engberg, 2001). Findings by Silver, Kramer, Greenwald, and Weissman (2001) suggest an 8.1% lifetime rate of suicide attempts post-TBI (mild, moderate, and severe) compared with 1.9% for the general population. Finally, clinically significant suicidal ideation has been identified in 21% to 22% of individuals with a history of TBI (Simpson & Tate, 2007). Nevertheless, limited research has been conducted regarding Veterans with a history of TBI and suicidal behaviors, communications, or thoughts. Increased understanding regarding precipitating and preventative factors associated with suicidal behavior among this high-risk population could be used to identify best assessment and treatment practices.

A recent report suggests that suicide is on the rise among Soldiers, with the year 2006 having the highest number of confirmed cases since 1990 (Lorge, 2008). Members of the U.S. Army were asked about current suicidal thoughts, and approximately 1% of the total sample of those who served in Iraq (2,411 of 222,620) endorsed some suicidal ideation (Hoge, Auchterlonie, & Milliken, 2006). Moreover, 467 of the 222,620 indicated that they thought about suicide "a lot" (Hoge, Auchterloine, & Milliken, 2006). As individuals transition from active duty to Veteran status, systems of health care also change. During the year 2009, 5,771,000 patients are expected to receive medical care within the Veterans Affairs (VA) system (Peake, 2008). This number includes approximately 333,000 Veterans who served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) (Peake, 2008). The need for research regarding TBI and suicide is further supported by findings that suggest that the rate of TBI among military personnel

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Cognitive Impairment and Suicidality

- “I knew what I wanted to say although I'd get into a thought about half-way though and it would just dissolve into my brain. I wouldn't know where it was, what it was and five minutes later I couldn't even remember that I had a thought. And that added to a lot of frustration going on….and you know because of the condition a couple of days later you can't even remember that you were frustrated.”

- “I get to the point where I fight with my memory and other things…and it’s not worth it.”

Brenner et al., 2009

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Emotional and Psychiatric Disturbances and Suicidality

- “I got depressed about a lot of things and figured my wife could use a $400,000 tax-free life insurance plan a lot better than….I went jogging one morning, and was feeling this bad, and I said, ‘well, it's going to be easy for me to slip and fall in front of this next truck that goes by…’"

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Loss of Sense of Self and Suicidality

- Veterans spoke about a shift in their self-concepts post-injury, which was frequently associated with a sense of loss
  - "…when you have a brain trauma…it's kind of like two different people that split…it's kind of like a split personality. You have the person that's still walking around but then you have the other person who's the brain trauma."

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How can we conceptualize risk in OEF/OIF/OND Veterans?

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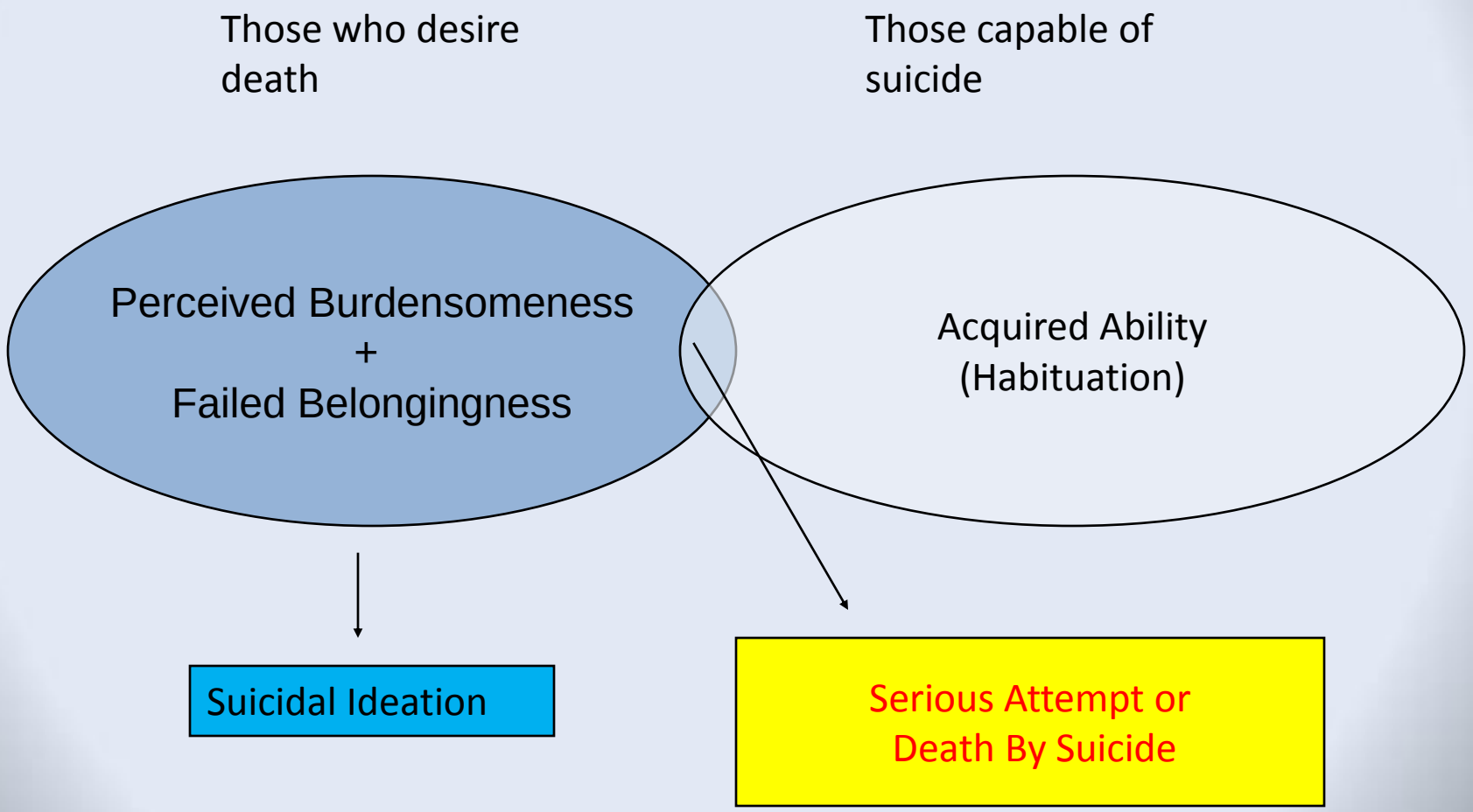
Interpersonal-Psychological Theory of Suicide Risk

Joiner 2005



A Qualitative Study of Potential Suicide Risk Factors in Returning Combat Veterans

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RESEARCH

A Qualitative Study of Potential Suicide Risk Factors in Returning Combat Veterans

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Nazanin Bahraini
Pamela J. Staves

According to the interpersonal-psychological theory of attempted and completed suicide (Joiner, 2005) suicide-related behavior is contingent upon three factors: acquired ability, burdensomeness, and failed belongingness. Qualitative research methodology was employed to explore these concepts among a group of returning Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) combat veterans. A sample of 16 individuals participated in interviews. Themes emerged regarding combat as a context for exposure to pain, subsequent coping strategies, and perceptions of burdensomeness, failed belongingness, and increased pain tolerance. Suicidal behavior was also articulated as a means of coping with risk factors outlined by Joiner. These results highlight the potential utility of this theory for OEF/OIF veterans. Interventions aimed at decreasing emotional dysregulation, and lessening perceptions of burdensomeness and failed belongingness may reduce risk for suicidal behavior.

While the ability to identify factors that make an individual more or less likely to engage in suicidal behavior has significant clinical utility (Beck, Steer, Kovacs, & Garrison, 1985; Jobes & Mann, 1999), such knowledge does not allow us to predict who will die by suicide. Recent work by Joiner (2005) represents years of theory building, refinement, and empirical validation aimed

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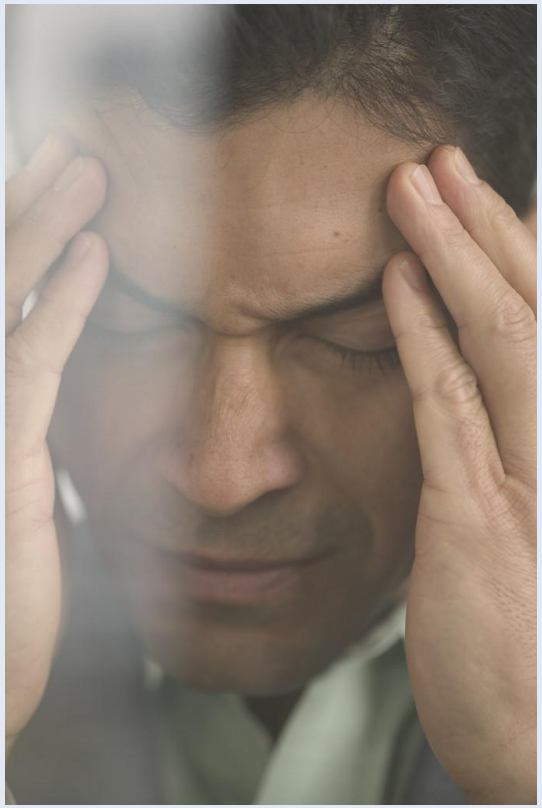
Themes

- Combat experiences were a setting for exposure to pain
- It takes more to be hurt now than in the past
- Increased tolerance for pain in conjunction with a variety of maladaptive coping strategies



Pain

- “I think that during the time that I was overseas I ah, kind of lost connection with reality and lost connection with my feelings…if you don’t have any emotions, then you are not scared or afraid either, which really helps you to get through the days in such a dangerous environment.”

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Belongingness

- Feeling disconnection from civilians and/or society in general

- “I separate myself from society, that part of society. I don’t know how to deal with those people….I just keep myself away.”

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Burdensomeness

- “I feel like I am burden, 100%, I don’t feel like I belong anywhere … like if I'm out with some friends, I don't feel like I belong. Family, I'm the outsider.”

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Other considerations

- Document
  - The risk level
  - The basis for the risk level
- Seek consultation / supervision as needed
- Suicide risk will need to be reassessed at various points throughout treatment, as a patient's risk level will wax and wane.

Jacobs 2003

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http://www.mirecc.va.gov/visn19